Form 103

Revised 6/05

KENTUCKY
OFFICE OF WORKERS' CLAIMS
Application for Resolution of Hearing Loss Claim
Claim No. _____

..... **Plaintiff**	**vs.**	..... **Defendant/Employer**
..... **Social Security Number**		..... **Street Address**
..... **Birth Date**		..... **City/State/Zip Code**
..... **Street Address**		..... **Insurance Carrier**
..... **City/State/Zip Code**		..... **Street Address**
..... **County**		..... **City/State/Zip Code**
..... **Phone Number**		..... **Other Defendant**
Filed:		..... **Street Address**
		..... **City/State/Zip Code**
		Reason for Joinder:
		.....
		.....
		..... **Other Defendant**
		..... **Street Address**
		..... **City/State/Zip Code**
		Reason for Joinder:
		.....
		.....

I. Nature of Injury

1. Plaintiff states that on the ..... day of ....., 20....., (day) (month) (year) he/she sustained or became disabled due to occupational hearing loss arising out of and in the course of his/or her employment.

2. Plaintiff became aware of this condition on _____

3. State the date and means by which plaintiff gave notice of the injury to employer.

_____

_____

4. Place of last exposure _____

(city) (county) (state)

5. Nature of the work in which the plaintiff was engaged at the time of exposure _____

_____

6. How did exposure to the disease occur? (Describe in detail) _____

_____

II. Personal Data

7. Name and address of last school attended: _____

8. Highest grade completed in school:_____

9. GED awarded: _____ yes _____no

10. Professional or vocational degrees, certificates, or licenses: _____

_____

_____

11. Dependents:

Name	Social Security Number	Relationship

12. Has plaintiff previously filed for or received workers' compensation benefits?

___yes ___no; if yes, give dates, nature of injury or disease and any award of benefits received: _____

_____

III. Employment Data

15. Type of work performed at date of occupational disease: _____

16. Describe the physical requirements of plaintiff's customary job: _____

_____

_____

17. Weekly wage at date of occupational disease: _____ Attach copy of any proof of wages, such as paycheck stub, W-2, etc.

18. Has plaintiff returned to work? ___ yes ___no; if yes, name and address of current employer and description of job currently being performed: _____

_____

19. Is plaintiff exposed to occupational noise in his/her current job? ____ yes ____ no

20. Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? _____yes, _____no

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Plaintiff herein being duly sworn, states that the statements in this application and in Form 104, 105, and 106 are true. This the _____ day of _____ 20__.

_____

Plaintiff's Signature

Subscribed and sworn to before me this _____ day of _____ 20___.

_____

Notary Public

My Commission expires: _____ County: _____

Prepared and submitted by: _____

Signature/Representative for Plaintiff

_____

Title

_____

Street Address

City/State/Zip Code

Telephone Number

Instructions for
Completion of Forms 101, 102 and 103

Form 101 - Application for Resolution of Injury Claim

1. All sections of this form must be completed, and must be accompanied by the following:
- a. Form 104 (Plaintiff's Employment History)
- b. Form 105 (Plaintiff's Chronological Medical History)
- c. Form 106 (Medical Waiver and Consent)
- d. Medical report describing and supporting the injury which is the basis of the claim.
- e. Proof of Wages, including W-2's, paycheck stubs, etc.

2. All information must be typewritten.

3. File the original of this form and sufficient copies for all named defendants with the **Office of Workers' Claims**, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky, 40601.

4. If you have no telephone number, please list a number at which you may be contacted.

5. If you have questions, call 1-800-554-8601

Form 102 - Application for Resolution of Occupational Disease Claim, and Form 103 - Application for Resolution of Hearing Loss Claim

1. All sections of this form must be completed, and must be accompanied by the following:
- a. Form 104 (Plaintiff's Employment History)
- b. Form 105 (Plaintiff's Chronological Medical History)
- c. Form 106 (Medical Waiver and Consent)
- d. Medical report supporting the occupational disease
- e. Proof of Wages, including W-2's, paycheck stubs, etc.
- f. Social Security earnings record release form.

2. This form may be filed in combination with an Application for Resolution of Injury Claim (Form 101) if both benefits are sought. Information provided should be current through the date application is signed by plaintiff.

3. All information must be typewritten.

4. File the original of this form and sufficient copies for all named defendants with the **Office of Workers' Claims**, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky, 40601.

5. If you have questions, call 1-800-554-8601

Note: Special attention should be given to stating the correct name and address of the employer and insurance carrier. Otherwise, claim processing may be delayed.

Revised January 25, 2005